The L.E.A.H. (Lending Every Amputee Hope) Fund

COMMUNITY FOUNDATION OF THE OZARKS

APPLICATION FOR A GIFT OF HOPE

Application for assistance is based on current or on-going need of amputation. Applications for assistance will be individually evaluated by a committee after completion of this form and verification from your health care provider of medical condition. Preference is given to but not limited to those residing in Southwest Missouri. Maximum amount available is $150 per year/per person to be used towards but not limited to medical/DME supplies or items from prosthetic companies to improve the quality of life for individuals with challenges associated with limp amputation. Information provided in this application is strictly confidential and will be used only for the purpose of grantmaking by the Community Foundation of the Ozarks.

Patient Name:_____ DOB: _____ SS#_____

Parent/Guardian Name(s):_____

Home Address: _____ County:_____

City_____ St____ Zip _____ Email: _____

Patient/Parent/Guardian Phone:_____ Other Phone (if applicable):_____

Patient/Parent/Guardian Employer (if applicable):_____

Patient Medical Diagnosis:_____

Date of amputation: _____ Amputation location on body:_____

Physician Name:_____Phone:_____ Fax:_____

The LEAH Fund committee will contact your physician to confirm your amputation diagnosis.

Amount Requested ($150 maximum): _____

Please state the intended use for the funds requested (equipment, medical supplies, camp fees, items from prosthetic company-please be specific):

_____

_____

Other agencies from which you are currently receiving funds: _____

_____

Other services currently being provided: _____

_____

Health Coverage: ____No ____Yes If yes, Circle type: Personal Policy Through Employer Medicaid

CFO pays to invoice only. Cash is not provided.

The Leah Fund Application

By signing this form you are agreeing that the Community Foundation of the Ozarks can receive information verifying your amputation status. I hereby certify that myself or child is an amputee and this will assist in capital equipment or other needs directly related to the amputation. I also certify that the above information is true and correct. All information is confidential and will be used only for eligibility determination.

Date **Applicant/ Parent / Guardian**

Return applications via mail or scan/email to:

Rachel Tripp
Community Foundation of the Ozarks
P.O. Box 8960
Springfield, MO 65801
rtripp@cfozarks.org
Questions? Contact: 417-864-6199